

**EOA's Sage PLUS Program  
Medicare Prescription Drug Counseling Assistance Request**

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**City/Zip Code:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Check one:**      ☐ **Married**      ☐ **Single/Widowed**

**Do you have Medicare?** (red, white, blue card)      ☐ **YES**      ☐ **NO**

**Do you have Medicaid/MedQUEST from the State of Hawaii**      ☐ **YES**      ☐ **NO**

**Do you have one of the following plans?      Please circle your plan:**

AlohaCare Advantage      HMSA 65C Plus      Kaiser Senior Advantage

UHC MedicareComplete      Secure Horizons

**Financial Information is optional. You may qualify for the Extra Help in paying for Medicare Part D premiums, deductibles and co-insurance?**

**Annual Income: Individual - less than \$16,905**      ☐ **YES**      ☐ **NO**

**Couple – less than \$22,770**      ☐ **YES**      ☐ **NO**

(If married, total income for both spouses if married and living together)

**Resources: individual - less than \$11,500**      ☐ **YES**      ☐ **NO**

**Couple – less than \$23,000**      ☐ **YES**      ☐ **NO**

(If married and living together, total resources for both spouses – including savings, stocks and bonds, IRAs)

<b>Other Health Insurance and Prescription Coverage or Assistance– Check all that apply.</b>
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- |  |  |
|--|--|
| <input type="checkbox"/> VA/TRICARE for Life               | <input type="checkbox"/> SSI – limited income assistance |
| <input type="checkbox"/> State of Hawaii or County Retiree | <input type="checkbox"/> Medigap plan H, I, or J         |
| <input type="checkbox"/> FEHBP (federal retirees)          | <input type="checkbox"/> Pre-PACE Program at Maluhia     |
| <input type="checkbox"/> Union/Other Retiree Coverage      | <input type="checkbox"/> Employer group health plan      |
| <input type="checkbox"/> Prescription Drug Manufacturer    | (I or my spouse is still working)                        |

**Preferred Pharmacies : (Be specific – Times Kahala)**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**I would like help during coverage gap with**      ☐ **Name Brand**      ☐ **Generic**

**I would like my annual deductible to be**      \$0, \$100 \$180 \$265 (circle one)

**Would you use mail order pharmacy for additional savings?**      ☐ **YES**      ☐ **NO**

**Please compare other health plans for additional savings**      ☐ **YES**      ☐ **NO**

**Current Prescriptions used OR attached a list from your pharmacist**

<b>Drug Name and Strength (10 mg Lipitor)</b>	<b>Dosage (60 pills per month)</b>	<b>Monthly Cost</b>

**Instructions: Complete this form with as much information as possible.  
We cannot do a comparison without your list of medications, your zip code  
and phone number (in case we have questions).**

Please fax this form (both front and back), by December 1, 2006 to:

Sage PLUS Program    808-586-0185

**Or mail:**        Executive Office on Aging  
                     Sage PLUS Program  
                     250 S. Hotel Street, Suite 406  
                     Honolulu, HI 96813

*Please include, with my comparison, a listing of counseling events in  
my area.*    ☐ **Yes**        ☐ **No**